PROVIDER AGREEMENT
Children's Special Health Care Services (CSHCS) Program Addendum
State Form 51398 (7-03)
Indiana State Department of Health

Acknowledgement of Participation

- Payment will be based upon the Medicaid rate, in accordance with state statutes and regulations. Payment as determined by the CSHCS Program shall be accepted as payment in full. Balances cannot be billed to the family.
- Authorization of emergency services must be requested within five (5) days of services being provided
- CSHCS must be billed for all services provided to participants and participant/family may not be billed directly.

Having elected to participate within the Children's Special Health Care Services (CSHCS) Program, I acknowledge the above addendum relating to the CSHCS Program.

Provider DBA Name_____ Tax ID _____

Officer Name _____ Title _____

Signature _____Date_____